Michigan Senate Economic Development Committee
September 13, 2012 Public Testimony
From
Dennis McCafferty, Vice President Health Policy
The Economic Alliance for Michigan

Michigan's Certificate of Need Program - It's Not Broke, so why are we fixing it?

I. Introductions/Credentials
   A. Employer's perspective
      i. Detroit Edison, 25 years in healthcare benefit administration
      ii. Last 9 years as Director Employee Benefit Administration
   B. Chaired the Detroit Regional Chamber's Health Care Committee for 2 years
   C. Vice President for the Greater Detroit Area Health Council for 5 years
   D. Economic Alliance for Michigan for last 5 years, Vice President Health Policy
   E. Certified Employee Benefit Specialist & MBA

II. Free Market Supply and Demand
   A. Assumes consumers making informed choices on
      i. What they need,
      ii. What are the alternative costs and
      iii. Which of the alternative suppliers they can purchase it from.
   B. Assumes suppliers are competing with multiple other suppliers based upon
      i. cost and
      ii. quality
   C. Supply will rise and fall to meet Demand
   D. Increased Supply results in Lower Costs

III. Health Care Supply and Demand is different!
   A. Consumers (patients) are NOT able to make informed decisions on
      i. What they need (Doctors make this decision)
      ii. What are the alternative costs
         1. Cost information is generally not available and
         2. Patients, for the most part, are not the one paying for this service.
   B. Which alternative supplier is used (Doctors make this decision)
   C. Suppliers are NOT competing with multiple other suppliers based on
      i. Cost - information is generally not discussed prior to rendering service.
      ii. Quality - information is not standardized and often not made available to patients.
   D. Demand will rise and fall to meet Supply
   E. Increase Supply results in Higher Costs

IV. Health care cost increases with increased competition
   A. Small employer's cost for Health Insurance (Attachment A-Cost of health insurance for small employers in Michigan)
      i. In the communities with fewer hospitals, doctors and less high tech equipment and services, the cost of health insurance is lower.

ii. In the communities with more hospital, doctors and high tech equipment and services, the cost of health insurance is higher.
iii. As the supply of services increases (more competition) the cost for services also increases.

B. Roemer's Law of Demand

"Supply may induce its own demand where a third party practically guarantees reimbursement of usage." (Attachment B – Roemer's Law of Demand)

i. Dartmouth Atlas Project has consistently shown a positive association between the supply of staffed hospital beds per 1000 residents and the hospitalization rate for medical conditions among Medicare patients. (More patients are admitted for longer periods of time when excess hospital-bed capacity exists in a community.)
ii. As the supply for hospital beds per 1000 persons in a community rises, not only that the prices may not fall, but will increase instead because of the greater marginal cost of the increased supply must be covered. ($300 million for a new hospital)
iii. Reasons for supply-induced demand;
    1. Difference between effective care and preference-sensitive care.
    2. Medicare payments are often based upon treatments rendered rather than outcomes with only loose overall budget constraints.

V. Proposed Bill would undue recent victories for those wishing to control health care cost in Michigan.

A. Hospital Bed Standards

i. CON Standards for Hospital Bed Standards were reviewed in 2011
ii. Standards underwent extensive review by a 12 member advisory committee that included 9 hospital experts plus a consumer, purchaser and payer.
    1. Six meetings of the Standard Advisory Committee plus 12 workgroup meeting were held to review need for and location of hospital bed capacity in Michigan.
    2. Michigan State University Department of Geography was hired to provide technical support in identifying where people live and where hospitals should be located to best serve Michigan's population.
    3. Conclusion reached by MSU study was that 98% of Michigan's citizens already live within 30 minutes drive time of a hospital and that we currently have 6,700 more licensed hospital beds than are needed to serve Michigan's citizens. This 6,700 represent 25% of existing licensed hospital bed capacity.
    4. The Advisory Committee also reviewed and approved a process that would result in reducing the number of licensed beds in the over-bedded urban counties.
    5. The Advisory Committee approved these recommendations on a vote of 11 to 1.
    6. The only dissenting vote on the advisory committee was the representative of McLaren Health System.
iii. These proposed changes in the Hospital Bed Standards recommended by the Advisory Committee were reviewed by CON Commission.
    1. The Commission unanimously approved taking Proposed Action to adopt the recommendations of the Advisory Committee at their December 2011meeting and sent these out for public comment.
    2. The only public comment in opposition to these proposed changes in the hospital bed standard was from McLaren Health System and two other hospitals expressed concern regarding the proposal to reduce excess beds in urban counties. All other hospitals in Michigan supported these proposed changes.

3. CON Commission voted unanimously to take Final Action on these proposed hospital bed rule changes at their June 2012 meeting.
4. The Michigan Department of Community Health (not the CON Commission) reviewed the McLaren application to build a hospital in Clarkston and found that this application failed to meet the CON standards for building a new hospital.

B. Health care is complex. Balancing reasonable access, insuring high quality and helping keep healthcare affordable require the input of many health care professionals, purchasers, consumers and payers. This thoughtful and deliberative process must be transparent and be free from political considerations. The Michigan CON process is able to accomplish this and has served the best interest of all of the citizens of Michigan.

VI. No new Jobs from proposed new hospital:
- A. This proposed hospital in Clarkston is for a small Community Hospital (200 beds) providing routine medical services to local residents.
- B. This proposed new hospital would <u>not</u> be providing;
  - i. major trauma services,
  - ii. major cardiac services
  - iii. Pediatric or Neonatal service
- C. This proposed hospital will <u>not</u> be employing persons involved in;
  - i. Research and development of new medical devices or equipment, or
  - ii. Research or manufacturing of pharmaceuticals
- D. The persons employed at this proposed new hospitals are the same doctors and support staff who are currently providing these same routine services for the Clarkston residents at St Joe Pontiac, Huron Valley-Sinai, the two Beaumont hospital, Crittenton and Genesys.
- E. As the patient volume moves for the existing hospitals to the proposed new hospitals, the existing hospitals will end-up reducing their staff in response to this loss of patients.
- F. The result of building this new hospital is a relocation of existing jobs and a change in the employee's commute to work. (No additional Jobs for the Community)

VII. Allowing legislative end-runs to the CON process weakens and may result in the collapse of the Michigan CON process. Who is disadvantaged by weakening or eliminating Michigan's CON program?
- A. Not-for-profit hospitals in urban communities by losing their market share of patients with better insurance, lower risk and higher margin medical services.
- B. Not for profit Rural Hospitals who would lose services to for-profit imaging and surgical centers that would be built in the absence of CON.
- C. Employers who provide health care insurance for its employees because costs will increase.
- D. State and Federal government that funds Medicare and Medicaid programs because costs will increase.
- E. Taxpayers that fund the US and State government's budget for health care for their employees, for Medicare and Medicaid.
- F. Healthcare Consumers by making healthcare cost more and CON quality the controls weakened.

VIII. Michigan's CON process is not broke so why are we thinking of fixing it?
- A. The Michigan CON process was totally revamped in 2002 and has served the citizens of Michigan well.
- B. Consumers, purchasers and payers currently all have a place on the CON Commission.

C. The Commission establishes policy with the help of subject matter experts in a very open and transparent process.
D. Decisions on individual applications are made by Michigan Department of Community Health staff, based upon the CON Standards established by the CON Commission.
E. The CON Commission does not nor is any of the Commissioners involved in the CON application approval process.
F. This separation of policy making and application approval process has made the Michigan CON process one of the best in the US.